

1. A return on a provider's net equity shall be an allowable cost area.
2. The amount of return on a provider's net equity shall not exceed twelve percent (12%).
3. An owner's net equity is comprised of investment capital and working capital. Investment capital includes the investment in building, propriety and equipment (cost of land, mortgage payments toward principle and equipment purchase less the accumulative depreciation). Working capital represents the amount of capital which is required to insure proper operation of the facility.
4. The return on owner's net equity shall be payable only to proprietary providers.
5. A provider's return on owner's net equity shall be apportioned to the Medicaid program on the basis of the provider's Medicaid program reimbursable recipient resident days of care to total resident days of care during the cost-reporting period. For the purpose of this calculation, total resident days of care shall be the greater of ninety percent (90%) of the provider's certified bed capacity or actual occupancy during the cost year.

(8) Reporting Requirements

(A) Annual Cost Report

1. Each provider shall establish a twelve (12)-month period which is to be designated as the provider's fiscal year. An annual cost report for the fiscal year shall be submitted by the provider to the department on forms to be furnished for that purpose. The completed forms shall be submitted by each provider within ninety (90) days following the close of its fiscal year.
2. Unless adequate and current documentation in the following areas has previously been filed with the department, authenticated copies of the following documents must be submitted with the cost reports: authenticated copies of all leases related to the activities of the facility; all management contracts, all contracts with consultants; federal and state income tax returns for the fiscal year; and documentation of expenditures, by line item, made under all restricted and unrestricted grants. For restricted grants, a statement verifying the restriction as specified by the donor.
3. Adequate documentation for all line items on the uniform cost reports must be maintained by the facility and must be submitted to the department upon request.
4. Following the ninety (90)-day period, payments will be withheld from the facility until the cost report is submitted. Upon receipt of a cost report prepared in accordance with these rules, the payments that were withheld will be released.
5. If requested in writing, a thirty (30)-day extension of the filing date may be granted for good cause shown.
6. The termination of or by a provider of participation in the program or a change of ownership requires that the provider submit a cost report for the

State Plan TN# 92-18

Supersedes TN# 88-22

91-40 medico

Effective Date September 1, 1992

Approval Date JUN 06 2001

period ending with the date of termination or change. The cost report is due within forty-five (45) days of the date of termination or change. Cost reports under this paragraph shall conform to the principles of section (7). The final payment due providers shall be withheld until their cost report is filed.

(B) Certification of Cost Reports

1. The accuracy and validity of any cost report must be certified. Certification must be made by one (1) of the following persons (who must be authorized by the governing body of the facility to make such certification and will furnish proof of such authorization): an incorporated entity, an officer of the corporation; for a partnership, a partner; for a sole proprietorship or sole owner, the owner; or for a public facility, the chief administrative officer of the facility. The cost report must also be notarized by a licensed notary public.

2. Certification Statement

Form of Certification

Misrepresentation or falsification of any information contained in this report may be punishable by fine and/or imprisonment under state or federal law.

Certification by officer or administrator of provider:

I hereby certify that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared by _____ (Provider's Name(s) and number(s)) for the cost report beginning _____ and ending _____, and that to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted.

Signature

Title

Date

(C) Adequacy of Records

1. The provider must make available to the department or its duly authorized agent, including federal agents from Health and Human Services, at all reasonable times, the records as are necessary to permit review and audit of provider's cost reports. Failure to do so may lead to sanctions stated in section (8) of this rule or other sanctions available in section (9).

2. All records associated with the preparation and documentation of the data associated with the cost report must be retained for seven (7) years from the cost report filing date.

(D) Accounting Basis

1. The cost report submitted must be based on the accrual basis of accounting.

2. Governmental institutions that operate on a cash or modified cash

State Plan TN# 92-18
Supersedes TN# 88-22
91-48 pending

Effective Date September 1, 1992
Approval Date JUN 06 2001

basis of accounting may continue to use those methods, provided appropriate treatment of capital expenditures is made.

(E) Audits

1. Cost reports shall be based upon the provider's financial and statistical records which must be capable of verification by audit.

2. If the provider has included the cost of a certified audit of the facility as an allowable cost item to the plan, a copy of that audit report and accompanying letter shall be submitted without deletions.

3. The annual cost report for the fiscal year of the provider may be subject to audit by the Department of Social Services or its contracted agents. Twelve (12)-month cost reports for new construction facilities required to be submitted under section (4) of this rule may be audited by the department or its contracted agents prior to establishment of a permanent rate.

4. The department will conduct a desk review of all cost reports within six (6) months after submission by the provider and shall provide for on-site audits of facilities wherever cost variances or exceptions are noted by their personnel.

5. The department shall retain the annual cost report and any working papers relating to the audits of these cost reports for a period of not less than seven (7) full years from the date of submission of the report or completion of the audit.

6. Those providers having an annual Title XIX bed-day ratio on total bed-days or certified beds of greater than sixty percent (60%) and/or an annual Title XIX payment of two hundred thousand dollars (\$200,000) or more shall be required, for at least the first two (2) fiscal years of participation in the plan, to have an annual audit of their financial records by an independent certified public accountant. The auditor may issue a qualified audit report stating that confirmations of accounts receivable and accounts payable are not required by the plan. For the purposes of the paragraph, the Department of Social Services will only accept an unqualified opinion from a certified public accounting firm. A copy of the audit report must be submitted to the department to support the annual cost report of the facility.

(9) Sanctions and Overpayments

(A) Sanctions may be imposed against a provider in accordance with 13 CSR 70-3.030 of the Missouri Code of State Regulations and other federal or state statutes and regulations.

(B) In the case of overpayments to providers based on, but not limited to, field or audit findings or determinations based on a comprehensive operational review of the facility, the provider shall repay the overpayment in accordance with the provisions as set forth in 13 CSR 70-3.030.

(10) Exceptions

(A) For those Medicaid-eligible recipient-patients who have concurrent Medicare Part A skilled nursing facility benefits available, Missouri Medical Assistance

State Plan TN# 92-18

Supersedes TN# 88-22

Effective Date September 1, 1992

Approval Date JUN 06 2001

program reimbursement for covered days of stay in a qualified facility will be based on the coinsurance as may be imposed under the Medicare program.

(B) The Title XIX reimbursement rate for out-of-state providers shall be set by one (1) of the following methods:

1. For providers which provided services of less than one thousand (1,000) patient days for Missouri Title XIX recipients, the reimbursement rate shall be the rate paid for comparable services and level of care by the state in which the provider is located; and

2. For providers which provide services of one thousand (1,000) or more patient days for Missouri Title XIX recipients, the reimbursement rate shall be the lower of --

A. The rate paid for comparable services and level of care by the state in which the provider is located; or

B. The rate calculated in sections (4) and (6) of this rule.

(11) Payment Assurance

(A) The state will pay each provider, which furnished the services in accordance with the requirements of the state plan, the amount determined for services furnished by the provider according to the standards and methods set forth in these regulations.

(B) Where third party payment is involved, Medicaid will be the payor of last resort with the exception of state programs such as Vocational Rehabilitation and the Missouri Crippled Children's Service. Procedures for remitting third-party payments are provided in the Missouri Medical Assistance program provider manuals.

(12) Provider Participation. Payments made in accordance with the standards and methods described in this rule are designed to enlist participation of a sufficient number of providers in the program so that eligible persons can receive medical care and services included in the state plan at least to the extent these services are available to the general public.

(13) Payment in Full. Participation in the program shall be limited to providers who accept as payment in full for covered services rendered to Medicaid recipients, the amount paid in accordance with these regulations and applicable co-payments.

(14) Plan Evaluation. Documentation will be maintained to effectively monitor and evaluate experience during administration of this plan.

State Plan TN# 92-18
Supersedes TN# 88-22
 91-48 pending

Effective Date September 1, 1992
Approval Date JUN 06 2001

APPENDIX: ROUTINE COVERED
MEDICAL SUPPLIES AND SERVICES

ABD Pads
A&D Ointment
Adhesive Tape
Aerosol Inhalators, Self-Contained
Aerosol, Other Types
Air Mattresses, Air P.R. Mattresses
Airway-Oral
Alcohol
Alcohol Plasters
Alcohol Sponges
Antacids, Nonlegend
Applicators, Cotton-tipped
Applicators, Swab-Eez
Aquamatic K Pads (water-heated pad)
Arm Slings
Asepto Syringes
Baby Powder
Bandages
Bandages-Elastic or Cohesive
Bandaids
Basins
Bed Frame Equipment (for certain immobilized bed patients)
Bed Rails
Bedpan, Fracture
Bedpan, Regular
Bedside Tissues
Benzoin
Bibs
Bottle, Specimen
Canes
Cannula-Nasal
Catheter Indwelling
Catheter Plugs
Catheter Trays

State Plan TN# 92-18
Supersedes TN# 88-22
91-48 pending

Effective Date Sept. 1, 1992
Approval Date JUN 06 2001

Catheter (any size)
Colostomy Bags
Composite Pads
Cotton Balls
Crutches
Customized Crutches, Canes and Wheelchairs
Decubitus Ulcer Pads
Deodorants
Disposable Underpads
Donuts
Douche Bags
Drain Tubing
Drainage Bags
Drainage Sets
Drainage Tubes
Dressing Tray
Dressings (all)
Drugs, Stock (excluding Insulin)
Enema Can
Enema Soap
Enema Supplies
Enema Unit
Enemas
Equipment and Supplies for Diabetic Urine Testing
Eye Pads
Feeding Tubes
Female Urinal
Flotation Mattress or Biowave Mattress
Flotation Pads and/or Turning Frames
Folding Foot Cradle
Gastric Feeding Unit
Gauze Sponges
Gloves, Unsterile and Sterile
Gowns, Hospital
Green Soap
Hand Feeding

State Plan TN# 92-18
Supersedes TN# 88-22
91-48 medicine

Effective Date September 1, 1992
Approval Date JUN 06 2001

Heat Cradle
Heating Pads
Heel Protector
Hot Pack Machine
Ice Bags
Incontinency Care
Incontinency Pads and Pants
Infusion Arm Boards
Inhalation Therapy Supplies
Intermittent Positive Pressure Breathing Machine (IPPB)
Invalid Ring
Irrigation Bulbs
Irrigation Trays
I.V. Trays
Jelly-Lubricating
Laxatives, Nonlegend
Lines, Extra
Lotion, Soap and Oil
Male Urinal
Massages (by nurses)
Mathiolate Aerosol
Medical Social Services
Medicine Dropper
Medicine Cups
Mouthwashes
Nasal Cannula
Nasal Catheter
Nasal Catheter, Insertion and Tube
Nasal Gastric Tubes
Nasal Tube Feeding
Nebulizer and Replacement Kit
Needles (various sizes)
Needles-Hypodermic, Scalp, Vein
Nonallergic Tape
Nursing Services (all) Regardless of level including the administration of
oxygen and restorative nursing care

State Plan TN# 92-18
Supersedes TN# 88-22
91-48 pending

Effective Date 9-1-1992
Approval Date JUN 06 2001

Nursing Supplies and Dressing (other than items of personal comfort or cosmetic)

Overhead Trapeze Equipment

Oxygen Equipment (such as IPPB Machines and Oxygen Tents)

Oxygen Mask

Pads

Peroxide

Pitcher

Plastic Bib

Pump (Aspiration and Suction)

Restraints

Room and Board (semi-private or private if necessitated by a medical or social condition)

Sand Bags

Scalpel

Sheepskin

Special Diets

Specimen Cups

Sponges

Steam Vaporizer

Sterile Pads

Stomach Tubes

Stool Softeners, Non-legend

Suction Catheter

Suction Machines

Suction Tube

Surgical Dressings (including Sterile Sponges)

Surgical Pads

Surgical Tape

Suture Removal Kit

Suture Trays

Syringes (all sizes)

Syringes, Disposable

Tape-For Laboratory Tests

Tape (nonallergic or butterfly)

Testing Sets and Refills (S & A)

State Plan TN# 92-18
Supersedes TN# 88-22
91-48 pending

Effective Date 9-1-1992
Approval JUN 06 2001

Tongue Depressors
Tracheostomy Sponges
Tray Service
Tubing-I.V. Trays, Blood Infusion Set, I.V. Tubing
Underpads
Urinary Drainage Tube
Urinary Tube and Bottle
Urological Solutions
Vitamins, Nonlegend
Walkers
Water Pitchers
Wheelchairs

State Plan TN# 92-18
Supersedes TN# 88-22
91-48 pending

Effective Date September 1, 1992
Approval Date JUN 06 2001

APPENDIX

Findings and Assurances

In conformity with the Title 42 CFR Section 447.253(a) and (b), the Department of Social Services/Division of Medical Services (DSS/DMS) makes the following findings and assurances:

- o ICF-MR rates of payment have been found to be reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations, and quality and safety standards.
- o The estimated weighted average proposed payment rate is reasonably expected to pay no more in the aggregate for ICF-MR, Long-Term Care services to state-operated facilities than the amount that the agency reasonably estimates would be paid for the services under the Medicare principles of reimbursement.
- o DSS/DMS provides long-term care facilities with an appeals or exception procedure that allows individual providers an opportunity to submit additional evidence and receive prompt administrative review of payment rates with respect to such issues as DSS/DMS determines appropriate.
- o DSS/DMS requires the filing of uniform cost reports by each participating provider.
- o DSS/DMS provides for periodic audits of the financial and statistical records of participating providers.
- o DSS/DMS published prior notice of said change in the newspaper in accordance with 42 CFR 447.205(d)(2)(ii).
- o DSS/DMS pays for long-term care services using rates determined in accordance with methods and standards specified in the approved State Plan.
- o The payment methodology used by the State for payments to ICF-MR facilities for medical assistance beginning January 1, 1990 can reasonably be expected not to increase payments solely as a result of a change of ownership in excess of the increase which would result from application of 42 U.S.C. 1861 (v)(1)(0) of the Social Security Act for all changes of ownership which occur on or after July 18, 1984, except for those changes made pursuant to an enforceable agreement executed prior to that date.

State Plan TN# 92-18
Supersedes TN# _____

Effective Date September 1, 1992
Approval Date JUN 06 2001

- o Section (2)(B)3 ICF-MR of the State's Prospective Reimbursement Plan for Non-State Operated Facilities for ICF-MR services provides that a change in ownership/management of a facility is not subject to review for rate reconsideration. Under the State's current methodology, ICF/MR payment rates do not increase as a result of a change in ownership.
- o The state assures that valuation of capital assets for purposes of determining payment rates for long-term care facilities will not be increased, solely as a result of a change of ownership, by more than as may be allowed under section 1902 (a)(13)(C) of the Act.
- o Except for preadmission screening for individuals with mental illness and mental retardation under Section 483.20(f), the methods and standards used to determine payment rates takes into account the costs of complying with the requirements of Part 483 Subpart B.
- o The methods and standards used to determine payment rates provide for an appropriate reduction to take into account the lower costs (if any) of the facility for nursing care under a waiver of the requirement in Section 483.30(c) to provide licensed nurses on a 24-hour basis.
- o The State establishes procedures under which the data and methodology used in establishing payment rates are made available to the public.

Related Information

In conformity with Title 42 CFR Section 447.255, DSS/DMS is submitting with the findings and assurances the following related information:

- o DSS/DMS has determined a projected weighted average per diem rate for ICF-MR, long-term care providers after the effective date of the proposed plan amendment.

Provider Type	Before 9/1/92	After 9/1/92	Increase/ Decrease
Non-State-Operated ICF/MR	\$121.81	\$130.67	\$8.86

- o DSS/DMS estimates there is no significant impact resulting from the change, either in short-term or long-term effects, as affecting -

- (1) The availability of services on a statewide and geographic area basis;
- (2) The type of care furnished; and
- (3) The extent of provider participation.

State Plan TN# 92-18

Supersedes TN# _____

Effective Date 9-1-199
JUN 06 2001
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9/1/92 | After
9/1/92 | Increase/
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|------------------------------|------------------|-----------------|-----------------------|
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State Plan TN# 92-18

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